FORM I: FAMILY PLANNING PROGRAM CLINIC SITES

Legal Business Name: Women's Health Care Center, INC **Clinic Site # 1_ of 1__**

CLINIC SITE INFORMATION: Complete this form for **EACH** clinic site that will provide Family Planning Program services funded under this enrollment.

Clinic Name:	**Women's Health Care Center, INC**				
Street Address:	**2914 S Buckner**			Suite:	B
City:	**Dallas**	County: **Texas**	Zip Code:	**75227**	HHSR: Dallas
Clinic APPOINTMENT Phone #:	**214-275-5256**				
Clinic PRIMARY Phone #:	**214-275-5256**		Fax:	**214-275-5284**	
Service Area *(counties to be served by this clinic site)*:	**Dallas**				
Contact Person:	Sherry Tenison				
Pharmacy License #:		Class:	Date of Pharmacy License Application Submission: 6-24-16		
TPI#:	156721606		NPI #:	1265462865	
Date of Medicaid Application Submission(if no TPI# or NPI#):					
Subcontractor Site:	☐ Yes	☒ No			
Mobile Site:	☐ Yes	☒ No			

CLINIC HOURS

DAY	HOURS OF OPERATION					
	Morning		Afternoon		Evening (after 5pm)	
	From	To	From	To	From	To
MONDAY	9	1	2	5		
TUESDAY	9	1	2	5		
WEDNESDAY	9	1	2	5		
THURSDAY	9	1	2	5		
FRIDAY	9	1	2	5		
SATURDAY	9	12				
SUNDAY	Closed					